Governor's Senior Prescription Drug

Task Force Report

August 30, 2001

The Honorable Governor Bob Holden
State Capitol
Jefferson City, MO 65101

Dear Governor:

Per your appointment and direction, the Governor's Senior Prescription Drug Task Force has met, taken testimony, deliberated, and concluded its study on this issue. The undersigned members of the Task Force are pleased to submit the attached report.

APPOINTMENT OF THE GOVERNOR'S SENIOR PRESCRIPTION DRUG TASK FORCE

In July, 2001, Governor Holden commissioned a 15 member bipartisan Task Force and charged them with developing a plan to help Missouri's seniors with the rising cost of prescription drugs. The Task Force: (1) evaluated the obstacles Missourians have in accessing affordable prescription drugs, particularly seniors, as well as other individuals who incur significant costs for prescription drugs; (2) searched for avenues to lower or eliminate those obstacles; and (3) made recommendations to be considered during the special session that is scheduled to begin September 5, 2001. The Governor appointed the following members to the Task Force:

Lt. Governor Joe Maxwell, Chair
Representative Joan Barry
Representative Charles Portwood
Senator Jim Mathewson
Senator Sarah Steelman
Rev. Karla Cooper
Dr. Nevada Lee
Sheppard Woolford
Representative Mark Abel
Representative Pat Naeger
Senator Ken Jacob
Senator Marvin Singleton
Ward Bond
Charles Jensen
Ollie Mae Stewart

The Task Force solicited testimony at the following five public hearings:

July 19, 2001	Jefferson City, Missouri
July 24, 2001	St. Louis, Missouri
August 7, 2001	Joplin, Missouri
August 16, 2001	Kansas City, Missouri
August 28, 2001	Columbia, Missouri

EXECUTIVE SUMMARY

A. Recommendations

The Task Force heard overwhelming testimony from seniors and health care professionals on the increasing difficulty seniors[1] face paying for their prescription drugs. Many seniors testified they are routinely forced to choose between paying for food or prescription drugs.

The idea that such a choice should even occur at this point in their lives is unconscionable. It is unacceptable for any senior to have to make the decision between buying food and buying medicine. One Division of Aging caseworker testified that in addition to sacrificing food, many seniors skip dosages of their medications in attempts to ration their medications, or turn off air conditioners or heaters, whichever the season may be, to reduce their monthly costs to afford their medications. Several senior citizens testified they have watched their lifetime savings depleted in only a few short years as a result of the exorbitant costs of pharmaceuticals they so desperately need.

The members believe that although the rising cost of drugs is truly an issue that will need to be addressed by the federal government, it is imperative the state provide relief immediately to the most needy seniors in the state. The Task Force heard testimony that although the $200 pharmacy tax credit was well intentioned, this tax credit is not meeting the needs of seniors. In addition, the tax credit program was initially estimated to cost $20 million. The cost is now nearing $90 million. Many seniors indicated the tax credit was too little, too late and not available to use at the time of the purchase of drugs. The Task Force recommends the $200 pharmacy tax credit be repealed and replaced with a senior pharmacy assistance program that shall begin enrollment by July 1, 2002. However, to ensure a safety net for seniors, if the senior pharmacy program is not implemented by July 1, 2002, then an alternative tax credit program will be considered by the General Assembly to replace the current tax credit.

Another recommendation is to provide a safety net for the most impoverished and medically needy individuals by increasing the Medicaid income limit to 100 percent of the federal poverty level and increasing resource limits to $1,500 for individuals and $2,500 for couples. According to testimony, Missouri has the lowest Medicaid income and resource limits in the nation. The resource limit has not been changed since 1972. These changes would provide a comprehensive healthcare benefit, including pharmaceutical coverage, to some of the most vulnerable individuals in the state. The costs of these healthcare benefits will be shared by the federal and state governments, with the federal government paying approximately sixty percent of the cost.

The Task Force recommends the program established should not exceed 200 percent of the federal poverty level. It should exclude individuals currently receiving Medicaid and individuals with adequate third party insurance (those plans with an actuarial value that is greater than or equal to coverage provided by senior pharmacy program benefit). This program should incorporate a 6-month crowd out period and a minimum residency requirement to be eligible for the program.

The Task Force had four guiding principles for establishing a meaningful pharmacy assistance program for the most needy seniors in Missouri:

- Create a pharmacy benefit program with comprehensive drug coverage;
- Provide enrollees with responsible access to prescription drugs;
- Ensure the plan is affordable for recipients yet fiscally responsible for the state; and
- Make all stakeholders share in the cost of the program.

An important component of the plan should be that it is subject to appropriations without compromising the core advantages of the plan.

B. Plan Design and Management

The Task Force recommended the following provisions as part of the pharmacy benefit design:

- Co-insurance according to income level and no cap on recipient co-insurance amount. Recommend a cap on state expenditures up to but not to exceed $5,000 per recipient.
- Enrollment fee of $25 per individual for first income tier (up to $12,000 for an individual and $17,000 for a couple) and $35 per individual for the second income tier ($12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple).
- Deductible of $250 for first income tier and $500 for second income tier. Further, the administering authority should recommend changing the deductible amount as one of the cost control measures for the program. **Comment:** The task force discussed various options to be recommended including deductibles, altering the co-insurance to make the plan more catastrophic in nature or, expanding co-insurance to allow for higher income seniors in the program.
- Establish an open enrollment period and require that all recipients re-enroll every year. In addition, there should be a provision that allows seniors to enroll within 30 days of qualifying events for income changes and age. The benefit year for the program should be July 1 through June 30.
- Income levels should be specifically stated in legislation rather than a percentage of the federal poverty level since this will be simpler for participants. First tier of income for program: up to $12,000 for an individual and $17,000 for a couple. Second tier of income for program: $12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple. There should be a "means test"; e.g., enrollees should attach a copy of last year’s income tax statement to their enrollment application for this program to demonstrate they meet the income requirements.
- Responsible access to prescription drugs through a balanced cost share. Enrollees should pay a percentage of the pharmacy cost rather than flat co-pay and the recommended percentage is 40 percent of the drug cost. Encourage the use of generic prescriptions through a mandatory generic program that would require the enrollee to pay in addition to the coinsurance amount the difference between the brand name drug and generic drug.

- Recommend legislation to require minimum manufacturer rebates of 15 percent for brand name drugs and 11 percent for generic drugs for pharmacy manufacturers who choose to have their drugs on the optional preferred drug list.
- Recommend paying pharmacies average wholesale price (AWP) minus 10.43 percent for brand name drugs and AWP minus 20 percent for generic drugs for ingredient reimbursement and a $4.09 dispensing fee.
- The Department of Health and Senior Services to administer the program and contract out with a third party to administer the senior pharmacy program.
- Incorporate various utilization management initiatives included in the Pharmacy Enhancement Program (PEP) in the Division of Medical Services in this senior pharmacy program.
- Provide a medical clearinghouse to educate seniors on pharmacy programs available to them in conjunction with other resources available.

C. Pharmacy Plan Oversight

The Task Force recommends the creation of a Commission to be involved in, and focused on, the difficult decisions associated with a comprehensive pharmaceutical benefit plan. The overall purpose of the Commission will be to provide proactive operational and financial oversight in an effort to determine how well the program is operating and whether changes may be necessary to remain within the program's budgeted appropriation. The Commission should have sole responsibility for approving changes to co-insurance, deductibles, enrollment fees, and drug exclusions in relation to pharmacy benefit trends and to make future recommendations on plan design. The Department of Health and Senior Services should oversee the program and contract out with a third party to administer the senior pharmacy program. In the event inadequate funding is available for the program, the administering authority could consider funding first tier income eligibles only, in addition to implementing other cost control measures.

D. Phase Two Recommendations

The Task Force further recommends the Department of Social Services, Division of Medical Services implement cost containment initiatives provided by Don Muse in his presentation for the Medicaid program at the Joplin hearing.

In the future, the General Assembly should look at expanding the income level of the senior pharmacy assistance program if the monies, including federal funds, should become available. They should also examine the possibility of increasing provider reimbursement in the Medicaid program to the usual and customary amounts and identify the costs associated with this recommendation. The General Assembly should also explore innovative ways to increase reimbursement to health care providers in rural areas of the state. Finally, the General Assembly should investigate developing a buy-in program for those seniors above the current income eligibility, at an actuarially sound level and consider developing a disease control model similar to the Illinois model.

E. Summary

It is becoming increasingly difficult and expensive for seniors, many of whom live on fixed incomes, to meet their prescription drug expenses. In many instances, seniors' incomes are too low to meet their basic needs and purchase prescription drug coverage plans. As prescription drugs play an ever-increasing role in overall medical care, affordable drugs coupled with management of their appropriate use will grow in importance. Therefore, it is critical our society demonstrate an increasing level of commitment to assist seniors in meeting their prescription drug needs through a comprehensive, affordable, and fiscally responsible prescription drug program.

On Wednesday, August 29, 11:25 a.m. the Prescription Drug Task Force adopted, with one dissenting vote, recommendations made by the Task Force that will be incorporated in the final report. The final vote shall be Friday, August 31, at 9:00 a.m. Dissenters shall be given the opportunity to attach their opinions to the report.

See Appendix A for the summary of all Task Force recommendations and Appendix B for adopted senior pharmacy assistance program plan design and its estimated cost.

1 For the purpose of this report a senior will be defined as a person 65 years of age or older.

Appendix A – Summary of Task Force Recommendations

Phase 1 Recommendations

Recommendation #1 - Repeal $200 pharmacy tax credit and replace with senior pharmacy assistance program that shall have begun enrollment by July 1, 2002. If the senior pharmacy program is not implemented by July 1, 2002 then an alternative tax credit program will be considered by the legislature.

Recommendation #2 - Raise Medicaid to 100 percent of the federal poverty level.

Recommendation #3 - Raise Medicaid resource limit to $1,500 for individuals and $2,500 for couples.

Recommendation #4 - Enrollees pay a percentage of pharmacy cost rather than a flat co-pay and the recommended percentage shall be 40 percent of the drug cost.

Recommendation #5 - Coinsurance according to income level and no cap on recipient coinsurance amount. Recommend a cap on state expenditures not to exceed $5,000 per recipient.

Recommendation #6 – AWP-10.43% for brand name drugs and AWP-20% for generic drugs for ingredient reimbursement and $4.09 dispensing fee to pharmacies.

Recommendation #7 – Incorporate various utilization management initiatives included in the Pharmacy Enhancement Program (PEP) program in the Division of Medical Services in this senior pharmacy program.

Recommendation #8 - Exclude individuals who are receiving Medicaid.

Recommendation #9 - Exclude individuals with adequate third party insurance (those with an actuarial value that is greater than or equal to coverage provided by the senior pharmacy program benefit).

Recommendation #10 – Incorporate a 6-month crowd out period and a residency clause to be eligible for the program.

Recommendation #11 - Enrollment fee of $25 for first income tier (up to $12,000 for an individual and $17,000 for a couple) and $35 for the second income tier ($12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple).

Recommendation #12 – Establish an open enrollment period and require that all recipients reenroll every year. In addition, there should be a provision that allows enrollment to be done within 30 days of qualifying events for income changes and age.

Recommendation #13 - Benefit year for program should be July 1 – June 30.

Recommendation #14 - Income levels should be specifically stated in legislation rather than a percentage of the federal poverty level since this will be simpler for participants. First tier of income for program: up to $12,000 for an individual and $17,000 for a couple. Second tier of income for program: $12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple. There should be a "means test" e.g. enrollees should attach copy of last year's income tax statement to their enrollment application for this program to demonstrate they meet the income requirements.

Recommendation #15 – Authorization of administering authority to make future recommendations on plan design.

Recommendation #16 – In the event there were inadequate funding available for the program, then the administering authority could consider funding first tier income eligibles only, in addition to implementing other cost control measures.

Recommendation #17 – The program established should not exceed 200% of the federal poverty level.

Recommendation #18 – Deductible of $250 for first income tier and $500 for second income tier. Further, the administering authority should recommend changing the deductible amounts as one of the cost control measures for the program.

Recommendation #19 – Recommend legislation to require minimum rebates of 15 percent for brand name drugs and 11 percent for generic drugs.

Recommendation #20 – Recommend Department of Health and Senior Services to oversee the program and contract out with a third party to administer the senior pharmacy program.

Recommendation #21 – Provide a medical healthcare clearinghouse to educate seniors about pharmacy programs available to them in conjunction with other resources available.

Recommendation #22 – Adopt recommendations made by the Task Force that will be incorporated in the final report. The final vote shall be Friday, August 31, at 9:00 a.m. Dissenters shall be given the opportunity to attach their opinions to the report.

Phase Two Recommendations

Recommendation #1 – Recommend DMS implement cost containment initiatives provided by Don Muse in his presentation for the Medicaid program at the Joplin hearing.

Recommendation #2 – In the future, the general assembly should look at expanding the income level of the senior pharmacy assistance program if the money, including federal funds, should become available.

Recommendation #3 – The General Assembly should further examine increasing provider reimbursement in the Medicaid program to the usual and customary amounts and identify the costs associated with this recommendation.

Recommendation #4 – The General Assembly should examine innovative ways to increase reimbursement to health care providers in rural areas of the state.

Recommendation #5 – In the future, the General Assembly should consider developing a buy-in program for those seniors above the current income eligibility, at an actuarially sound level.

Recommendation #6 – In the future, the General Assembly should consider developing a disease control model similar to the Illinois model.

Appendix B - Adopted Senior Pharmacy Assistance Program

Benefit Design		
	Tier 1	Tier 2
Income		
	Less than 12,000 for an individual	Less than 17,000 for an individual
	Less than 17,000 for a couple	Less than 23,000 for a couple
Enrollment Fee	$25 per year	$35 per year
Deductible	$250	$500
Annual Benefit	$5,000	$5,000
Coinsurance	40%	40%
Eligible Seniors	287,820	94,830
Participants		
FY 03	37,260	13,220
FY 04	57,310	20,330
State Program Cost		
State Cost Net of 15% Brand / 11% Generic Rebates		
FY 03	$45 - 52 million	
FY 04	$75 - 85 million	
Clearinghouse	**$1.7 million ***	

* Cost estimate provided by Senator Singleton